

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

7428

CERTIFICATE OF DEATH

07359

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>10 mos. 2 weeks</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Sam</u> Last <u>Badrich</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1960</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 6, 1890</u>			
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith & Maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Industry</u>					
11. BIRTHPLACE (State or foreign country) <u>Serbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Samuel Badrich</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-10-6801</u>					
17. INFORMANT <u>Mrs. Geo. S. Badrich</u>				Address <u>307 Vista St. Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calculation - pneumonia</u> DUE TO <u>ruled sigmoid colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>153.3</u> DUE TO (c) <u>153.3</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic emphysema & cerebral infarct & laryngitis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1960</u> to <u>June 26, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 26, 1960</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>L. L. Packard</u> M.D.				22b. DATE SIGNED <u>6/28/60</u>					
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packard Sr MD</u>				22d. ADDRESS <u>145 W. Washington St Hagerstown, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 29, 1960</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Horst</u>				ADDRESS <u>Hagerstown, Md.</u>					
25a. REC'D BY REGISTRAR <u>JUN 30 '60</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Horst</u>					

U.S. 350

CERTIFICATE OF DEATH

1953

1. Name of deceased: *George W. Brown*
2. Sex: *Male*
3. Age: *70*
4. Date of birth: *May 15, 1883*
5. Place of birth: *St. Louis, Mo.*
6. Date of death: *Nov 10, 1953*
7. Place of death: *St. Louis, Mo.*
8. Cause of death: *Heart disease*
9. Manner of death: *Natural*
10. Signature of physician: *[Signature]*
11. Signature of registrar: *[Signature]*
12. Date of registration: *Nov 15, 1953*

1

13. Name of informant: *George W. Brown*
14. Relationship to deceased: *Self*
15. Address of informant: *St. Louis, Mo.*
16. Date of interview: *Nov 15, 1953*
17. Name of informant: *George W. Brown*
18. Relationship to deceased: *Self*
19. Address of informant: *St. Louis, Mo.*
20. Date of interview: *Nov 15, 1953*
21. Name of informant: *George W. Brown*
22. Relationship to deceased: *Self*
23. Address of informant: *St. Louis, Mo.*
24. Date of interview: *Nov 15, 1953*
25. Name of informant: *George W. Brown*
26. Relationship to deceased: *Self*
27. Address of informant: *St. Louis, Mo.*
28. Date of interview: *Nov 15, 1953*
29. Name of informant: *George W. Brown*
30. Relationship to deceased: *Self*
31. Address of informant: *St. Louis, Mo.*
32. Date of interview: *Nov 15, 1953*
33. Name of informant: *George W. Brown*
34. Relationship to deceased: *Self*
35. Address of informant: *St. Louis, Mo.*
36. Date of interview: *Nov 15, 1953*
37. Name of informant: *George W. Brown*
38. Relationship to deceased: *Self*
39. Address of informant: *St. Louis, Mo.*
40. Date of interview: *Nov 15, 1953*
41. Name of informant: *George W. Brown*
42. Relationship to deceased: *Self*
43. Address of informant: *St. Louis, Mo.*
44. Date of interview: *Nov 15, 1953*
45. Name of informant: *George W. Brown*
46. Relationship to deceased: *Self*
47. Address of informant: *St. Louis, Mo.*
48. Date of interview: *Nov 15, 1953*
49. Name of informant: *George W. Brown*
50. Relationship to deceased: *Self*
51. Address of informant: *St. Louis, Mo.*
52. Date of interview: *Nov 15, 1953*
53. Name of informant: *George W. Brown*
54. Relationship to deceased: *Self*
55. Address of informant: *St. Louis, Mo.*
56. Date of interview: *Nov 15, 1953*
57. Name of informant: *George W. Brown*
58. Relationship to deceased: *Self*
59. Address of informant: *St. Louis, Mo.*
60. Date of interview: *Nov 15, 1953*
61. Name of informant: *George W. Brown*
62. Relationship to deceased: *Self*
63. Address of informant: *St. Louis, Mo.*
64. Date of interview: *Nov 15, 1953*
65. Name of informant: *George W. Brown*
66. Relationship to deceased: *Self*
67. Address of informant: *St. Louis, Mo.*
68. Date of interview: *Nov 15, 1953*
69. Name of informant: *George W. Brown*
70. Relationship to deceased: *Self*
71. Address of informant: *St. Louis, Mo.*
72. Date of interview: *Nov 15, 1953*
73. Name of informant: *George W. Brown*
74. Relationship to deceased: *Self*
75. Address of informant: *St. Louis, Mo.*
76. Date of interview: *Nov 15, 1953*
77. Name of informant: *George W. Brown*
78. Relationship to deceased: *Self*
79. Address of informant: *St. Louis, Mo.*
80. Date of interview: *Nov 15, 1953*
81. Name of informant: *George W. Brown*
82. Relationship to deceased: *Self*
83. Address of informant: *St. Louis, Mo.*
84. Date of interview: *Nov 15, 1953*
85. Name of informant: *George W. Brown*
86. Relationship to deceased: *Self*
87. Address of informant: *St. Louis, Mo.*
88. Date of interview: *Nov 15, 1953*
89. Name of informant: *George W. Brown*
90. Relationship to deceased: *Self*
91. Address of informant: *St. Louis, Mo.*
92. Date of interview: *Nov 15, 1953*
93. Name of informant: *George W. Brown*
94. Relationship to deceased: *Self*
95. Address of informant: *St. Louis, Mo.*
96. Date of interview: *Nov 15, 1953*
97. Name of informant: *George W. Brown*
98. Relationship to deceased: *Self*
99. Address of informant: *St. Louis, Mo.*
100. Date of interview: *Nov 15, 1953*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
081

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7377
CERTIFICATE OF DEATH

07360

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle VAUGHN Last BALDWIN				4. DATE OF DEATH Month JUNE Day 10 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 7 1960	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 4		IF UNDER 24 HRS. Hours 4 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME JOHN R BALDWIN				14. MOTHER'S MAIDEN NAME PAULINE STUM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT JOHN R BALDWIN HAGERSTOWN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 773.5 IMMEDIATE CAUSE (a) Pericarditis 720 Birthwt 3'10" DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 Days 3 Days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6/7/60 19 to 6/10/60 19, that (I) (we) last saw the deceased alive on 6/10/60 19, and that death occurred 6/11/60 from the causes and on the date stated above.							
22a. SIGNATURE Ralph F. Young				22b. DATE SIGNED 6/11/60		22c. PHYSICIAN'S NAME (Type) RALPH F YOUNG M D	
22d. ADDRESS William & 1st St, W							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/11/60		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL HOME Sharon M. Kautzer				25a. REC'D BY REGISTRAR DATE JUN 20 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2081202XV2

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PAGE 4

TO HOSPITAL

MAY BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILLED WITH

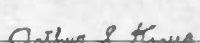
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7378

07361

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 874 FREDERICK STREET				d. STREET ADDRESS 874 FREDERICK STREET			
3. NAME OF DECEASED (Type or print) First Middle Last LEILA DAISY BARBER				4. DATE OF DEATH Month Day Year JUNE 8 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH OCT 15 1896		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME FRANKLIN POTTER				14. MOTHER'S MAIDEN NAME ALMA BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT SCOTT A BARBER		Address HAGERSTOWN MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Coronary atherosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Instant 5 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>D.C.</u> , 19 <u>57</u> to <u>June 8</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> 19 <u>60</u> and that death occurred at <u>8A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 10, 1960	
22c. PHYSICIAN'S NAME (Type) B B KNEISLEY M D				22d. ADDRESS 148 West Washington Street Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/10/60		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR'S NAME (Type) ADDRESS Charles M. Royer HAGERSTOWN MARYLAND				25a. REC'D BY REGISTRAR JUN 13 '60		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

file State board of Health, Baltimore, Maryland, and in 7 days, within 12 hours after death.

2

1
TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9-59

1
M
081
7379
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07362

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SHARON LYNN BARNHART</u>		4. DATE OF DEATH <u>JUNE 7 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1960</u>
9. AGE (In years last birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR <u>—</u> Months <u>1</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Barnhart</u>		14. MOTHER'S MAIDEN NAME <u>PATSY ANN GORDON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Henry Barnhart</u>		Address <u>615 Elizabeth Ave Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Summerville</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Creeping labor</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>2 mths</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 6</u> 19 <u>60</u> , to <u>June 7</u> 19 <u>60</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>June 7</u> 19 <u>60</u> , and that death occurred at <u>—</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis G. Graff, M.D.</u>		22b. DATE SIGNED <u>6-8-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS G. GRAFF, M.D.</u>		22d. ADDRESS <u>119 E. ANTIETAM ST. HAGERSTOWN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/8/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Mennoch - Greencastle, Penna.</u>		25a. REC'D BY REGISTRAR <u>JUN 10 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

2081272XV2

1373

1910

John Doe
Age 45
Married
Occupation: Farmer
Cause of Death: Heart Disease
Place of Death: Home
Date of Death: Jan 1, 1910
Signature: [illegible]
Physician: [illegible]

(1)

(1)

John Doe
Age 45
Married
Occupation: Farmer
Cause of Death: Heart Disease
Place of Death: Home
Date of Death: Jan 1, 1910
Signature: [illegible]
Physician: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7380
CERTIFICATE OF DEATH

07363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	c. LENGTH OF STAY in 1b <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CLEARSPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSP.</u>		d. STREET ADDRESS <u>1 R#1</u>	
3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>OMAR</u> Last <u>BLAIR</u>		4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1895</u>
9. AGE (In years last birthday) yrs. <u>64</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. construction</u>	
11. BIRTH PLACE (State or foreign country) <u>MERCERSBURG, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WARD BLAIR</u>		14. MOTHER'S MAIDEN NAME <u>MARIA SHAFFER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>205-09-9441</u>	
17. INFORMANT <u>MRS. ELSIE S. Blair, Clearspring, Ind., R. 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary emphysema</u> DUE TO (c) <u>chronic bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days -</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>1</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/23, 1960</u> , to <u>6/26, 1960</u> , that I last saw the deceased alive on <u>6/26, 1960</u> , and that death occurred at <u>2:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hornbaker</u>		ADDRESS (Street, city or town, state) <u>154 West Washington St.</u>	
DATE SIGNED <u>June 27, 1960</u>			
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M. D.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BRETHREN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MERCERSBURG, PA. R. 2</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Luning</u>		ADDRESS <u>MERCERSBURG, PA.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7381

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G265 6-22-60 et

07364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Academy Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lewis Middle Mc Kay Last Boward		4. DATE OF DEATH approx. Month June Day 3 , Year 1960 Unknown	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1892
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR: Months 11 Days 11 Hours 11 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Emanuel Boward		14. MOTHER'S MAIDEN NAME Margaret Springer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) W. W. I		16. SOCIAL SECURITY NO. 215-14-2503	
17. INFORMANT Fred Boward		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 Exposure - Probable DUE TO (b) Known Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Known PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Cirrhosis Liver & Chronic Alcoholism 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No Known Injury	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/12/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-17-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR JUN 20 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7382

07365

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 11 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS 117 E. High Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grafton Middle Finley Last BRASHEARS		4. DATE OF DEATH Month 6 Day 6 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 2 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Assembler		10b. KIND OF BUSINESS OR INDUSTRY Refrigeration	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Thomas Brashears		14. MOTHER'S MAIDEN NAME Sarah Peterman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219 05 2295	
17. INFORMANT Mrs. Ida Brashears		Address 117 E. High Street Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 332 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral thrombosis DUE TO (c) cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week 11 weeks unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis, Secubiti.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 11, 1960 to June 6, 1960 that (I) (we) last saw the deceased alive on June 6, 1960 and that death occurred at 3:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun,		22b. DATE SIGNED June 6, 1960	
22c. PHYSICIAN'S NAME (Type) Young E. Chun,		22d. ADDRESS 1500 Penna. Ave, Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 9-60	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md		25a. REC'D BY REGISTRAR DATE JUN 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

14

1382

THE HOUSE OF DEATH

07302

Washington

Barryman

Washington

Barryman

11 weeks

Shenandoah

Western Maryland State Hospital

117 E. High Street

Griffith Finley

BRASHEARS

Date: March 22 1888

March 22 1888

Barryman

Barryman

Barryman

Thomas Barryman

Barryman

219 OF 2202 E. High Street

Barryman

Barryman

Barryman

Barryman

Barryman

Barryman

Barryman

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

7434

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07366

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANSVILLE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAUGANSVILLE, MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY G. BURKHOLDER		4. DATE OF DEATH JUNE 24 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HONE	
11. BIRTHPLACE (State or foreign country) MAUGANSVILLE, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN E. HORST		14. MOTHER'S MAIDEN NAME ANNA GOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Edgar H. Burkholder - Hagerstown, Md.		Address RD 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 8 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1952 to June 24 1960 , that (I) (we) last saw the deceased alive on June 23 1960 and that death occurred at 255 A M, from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED 6/25/60	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/27/60	
23c. NAME OF CEMETERY OR CREMATORY MILLERS MENNONITE CEM.		23d. LOCATION (City, town, or county) (State) near Hagersburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A.E. Minnich - Greencastle, Penna.		25a. REC'D BY REGISTRAR DATE JUN 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

1

1933

CERTIFICATE OF DEATH

0238

WASHINGTON

MARYLAND

WASHINGTON

WICKHAM, LEE

WICKHAM, LEE

WICKHAM, LEE

WICKHAM, LEE

MARY

MARY

WICKHAM, LEE

WICKHAM, LEE

WICKHAM, LEE

WICKHAM, LEE

JOHN E. HORT

JOHN E. HORT

JOHN E. HORT - Hagerstown, Md.

10/10/33

U.S. Registrar - General's Office
10/10/33

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7383

CERTIFICATE OF DEATH

Reg. Dist. No. 07367

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FT. LONDON, PA.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 BELVIEW AVE.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Byers</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RICHMOND FURNACE, PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANKER BYERS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH HAISTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>204-03-7701</u>	
17. INFORMANT <u>CLYDE E. BYERS</u>		Address <u>ST. THOMAS, PA., R.1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>25 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Not on a line</u> to <u>2:15 PM</u> , that I last saw the deceased <u>San R. Rite 2 weeks ago</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>1135 Potomac AVE</u> DATE SIGNED <u>5 June 60</u>	
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.		PHYSICIAN'S NAME (Type) <u>Richard T. Binford</u> <u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/8/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PENNGER HILL Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>FT. LONDON, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hunsinger</u> ADDRESS <u>Mercersburg, Pa.</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunsinger</u>			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07368

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>nr. Chariton</u>		c. LENGTH OF STAY IN 1b <u>30 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Falling Waters RFD #1</u>	
3. NAME OF DECEASED (Type or print) <u>Nardi Leo Ceravalo</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13 1932</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
13. BIRTHPLACE (State or foreign country) <u>Falling Waters RFD</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. FATHER'S NAME <u>Dominick Ceravalo</u>		16. MOTHER'S MAIDEN NAME <u>Julia Allen</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <u>234 54 9897</u>	
19. INFORMANT <u>Mrs. Kathleen Jones</u>		20. ADDRESS <u>Falling Waters W. Va. RFD #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>850X</u>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from boat into water while fishing.</u>	
22a. TIME OF INJURY Hour <u>7</u> a.m. <u>2</u> p.m. Month, Day, Year <u>6/26/1960</u>	22b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River - nr. Chariton Wash. Md</u>	22d. (City or town) (County) (State) <u>nr. Chariton Wash. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Dittman, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edw. W. Dittman</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/28/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 29-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Marlowe W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. W. Dittman</u>		ADDRESS <u>7000 W. Baltimore Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
J. Edgar Hoover

RESIDENCE
1400 ...

DATE OF DEATH
Nov. 13 1932

AGE
50

SEX
M

RACE
W

RELIGION
U.S.A.

EDUCATION
High School

OCCUPATION
Director of FBI

CAUSE OF DEATH
Heart Disease

MANNER OF DEATH
Natural

PLACE OF DEATH
Home

DATE OF BURIAL
Nov. 15 1932

PLACE OF BURIAL
Catholic

NAME OF FUNERAL HOME
John J. ...

NAME OF MINISTER
Rev. ...

NAME OF CLERGYMAN
Rev. ...

NAME OF CLERGYMAN
Rev. ...

NAME OF CLERGYMAN
Rev. ...

NAME OF CLERGYMAN
Rev. ...

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NAME OF CLERGYMAN
Rev. ...

NAME OF PHYSICIAN
Dr. ...

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NAME OF PHYSICIAN
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NAME OF PHYSICIAN
Dr. ...

NAME OF PHYSICIAN
Dr. ...

7429

CERTIFICATE OF DEATH

Reg. Dist. No.

07369

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>5 yrs. 5 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah Margaret Clopper</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16, 1861</u>
9. AGE (In years last birthday) <u>98</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frederick County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hessong</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Kline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. A. Toms (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory collapse</u> 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Cerebral</u> DUE TO (c) <u>1 min</u> 1 mo		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fx hip</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>June</u> Day <u>1</u> Year <u>1960</u> Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>June 2</u> , 19 <u>60</u> . That I last saw the deceased alive on <u>June 1</u> , 19 <u>60</u> , and that death occurred at <u>4:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M E Byrkit</u>		ADDRESS (Street, city or town, state) <u>28 W Potomac</u> DATE SIGNED <u>6-3-60</u>	
PHYSICIAN'S NAME (Type) <u>M E Byrkit</u>		<u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Leitersburg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Leitersburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Smithsburg, Md</u>		ADDRESS <u>DATE JUN 10 '60</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1923

1

1

MAILED 11 10 1923

1. Name of deceased: *John J. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15 1878*

5. Place of birth: *New York City*

6. Usual residence: *123 Main St, New York City*

7. Cause of death: *Myocardial Infarction*

8. Date of death: *Nov 10 1923*

9. Time of death: *10:30 AM*

10. Place of death: *Home*

11. Signature of attending physician: *J. H. Jones*

12. Signature of registrar: *W. B. Brown*

13. Signature of coroner: *C. D. Green*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7436

Reg. D1729.71

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Hancock Md</u>		c. LENGTH OF STAY IN 1b <u>X</u> Rural 1 Hancock Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Little Pool Near Hancock Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Sparr</u> Last <u>Dickerhoff</u>		4. DATE OF DEATH Month <u>6.5.</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9.23.1922</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer E Dickerhoff</u>		14. MOTHER'S MAIDEN NAME <u>Bessie E Heller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>World War 2</u>	
17. INFORMANT <u>Ann M Dickerhoff</u>		Address <u>Rural 1 Hancock Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tried to Rescue fellow fireman</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-5-1960</u> Hour <u>3:35</u> a. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Canal</u>		20f. (City or town) (County) (State) <u>Hancock Washington Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. P. W. O. H.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. E. W. II. T. O. E.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/5/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.8.60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Houard J. Stone</u>		ADDRESS <u>Hancock Md</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hearn</u>	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male / Female]</p>		<p>3. AGE [Age]</p>	
<p>4. OCCUPATION [Occupation]</p>		<p>5. PLACE OF BIRTH [Place of birth]</p>		<p>6. DATE OF BIRTH [Date of birth]</p>	
<p>7. MARITAL STATUS [Married / Single / Widowed / Divorced]</p>		<p>8. CAUSE OF DEATH [Cause of death]</p>		<p>9. MANNER OF DEATH [Natural / Accidental / Suicide / Homicide]</p>	
<p>10. SIGNATURE OF MEDICAL EXAMINER [Signature]</p>		<p>11. SIGNATURE OF WITNESS [Signature]</p>		<p>12. DATE OF EXAMINATION [Date]</p>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

07372

Reg. Dist. No.....

7437

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Frederick</u> ✓	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Shilhamport - RFD</u>		LENGTH OF STAY (in this place) <u>7 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		TOWN <u>1011-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood church Home</u>				STREET ADDRESS (If rural give location) <u>14 East 5th St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u>		(Middle) <u>mary</u>		(Last) <u>Dieterich</u>		(Month) <u>June</u> (Day) <u>30</u> (Year) <u>1960</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct 21, 1885</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Justus Dieterich</u>				14. MOTHER'S MAIDEN NAME <u>Anna Catherine Zerlach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Messwagner, R#2</u> <u>Shilhamport, md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>170x</u>				ANTECEDENT CAUSE(S) DUE TO <u>Carcinoma of the breast</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>59</u> , to <u>June 30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>60</u> , and that death occurred at <u>7:20 A.M.</u> on <u>June 30</u> , 19 <u>60</u> , from the causes and on the date stated above.							
SIGNATURE <u>Lavin Hall</u>		M.D. <u>119 E - Chaptown</u>		ADDRESS (Street, city, town, state) <u>Frederick, Maryland</u>		DATE SIGNED <u>June 6/30/60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 2, 1960</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. REC'D BY REGISTRAR <u>JUL 6 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Finnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Bailey</u>		ADDRESS <u>Frederick, Maryland</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE WHERE DEATH OCCURRED

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

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EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

REGISTERED

1. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

2. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

3. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

4. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

5. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

6. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

7. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

8. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

9. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

10. I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief, and that the deceased was at the time of death a resident of the State of Minnesota.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

Item 18 File 267-2-15-60									
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07373									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport			c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bear Of 24 Potomac Street					d. STREET ADDRESS Bear Of 24 Potomac Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Melton Middle Samuel Last Ditlow					4. DATE OF DEATH Month June Day 28 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY Power Plant		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME William Ditlow					14. MOTHER'S MAIDEN NAME Mary Norris				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 09 9010		17. INFORMANT Mary E. Ditlow Address 820 Washington Ave. Hagerstown Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis with cortical necrosis DUE TO 600.0 Conditions, if any, which gave rise to immediate cause (b) Pyelonephritis (c) Benign prostatic hyperplasia adenocarcinoma prostate DUE TO 0 Benign prostatic hyperplasia adenocarcinoma prostate 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Williamsport		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Edward W. D. Ditto III M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 6/29/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30-60		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery			22d. LOCATION (City, town, or county) (State) Williamsport Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Edith D. Lual Williamsport Md					24a. REC'D BY REGISTRAR DATE JUL 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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07374

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown RFD #3		c. LENGTH OF STAY IN 1b 19 yrs.		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown R.F.D #3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Ridge Drive				d. STREET ADDRESS 1 Oak Ridge Drive		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Annie		Middle Camilla		Last Dorsey	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18 1900	
				9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crop Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Lloyd C. Weaver				14. MOTHER'S MAIDEN NAME Fannie Mc Namee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215 36 7081		17. INFORMANT Mr. Carl Dorsey 2204 Gay St. Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 254X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic heart disease 10 years DUE TO (c) Toxic thyroiditis 10 yrs. INTERVAL BETWEEN ONSET AND DEATH 1 wk.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1934 to 6.19.60, that (I) (we) last saw the deceased alive on 6.19.60, and that death occurred on 3.8.61, from the causes and on the date stated above.							
22a. SIGNATURE S. Earl Young				22b. DATE 6.20.60		22c. PHYSICIAN'S NAME (Type) S. Earl Young M.D.	
22d. ADDRESS 148 N. Potomac St., Hagerstown, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21-60		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City, town, or county) (State) Near Tilghmanton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edith W. Paul Williams				25a. REC'D BY REGISTRAR DATE JUN 22 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7385

CERTIFICATE OF DEATH

Reg. Dist. No.

07375

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	c. LENGTH OF STAY IN 1b 1 MONTH	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) 218 WOODPOINT AVE.		d. STREET ADDRESS /218 WOODPOINT AVE.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LULU First CATHERINE Middle DUTROW Last		4. DATE OF DEATH JUNE Month 18 Day 19 Year 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1881
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM D. ENGLEBERGER		14. MOTHER'S MAIDEN NAME ADELLA M. MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address MILLARD G. DUTROW (SAME AS ITEM #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). None.			INTERVAL BETWEEN ONSET AND DEATH 8 days Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 10, 1960 to June 18, 1960 , that I last saw the deceased alive on June 17, 1960 , and that death occurred at 9 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 119 North Potomac St. 6-18-60			
ACTUAL SIGNATURE R.A. Bell		M.D. 119 North Potomac St. 6-18-60	
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/20/60	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.	22d. LOCATION (City, town, or county) (State) FREDERICK MD.
23. FUNERAL DIRECTOR'S SIGNATURE W.J. Normant, Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '60	24b. REGISTRAR'S SIGNATURE Orthur S. Kraus

18. The first of these is the

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7386

07376

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS 855 Summit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Magdalene Caroline Eiler				4. DATE OF DEATH Month Day Year June 1 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 18, 1891	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hag. Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Lokstine				14. MOTHER'S MAIDEN NAME Flora A. Stockslager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Murray E Eiler 855 Summit Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Thrombosis of int. carotid artery DUE TO (b) Atherosclerosis of vessel Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH 5 days ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 30 May 1960 to 1 June 1960 , that (I) (we) last saw the deceased alive on June 19 60 and that death occurred at 8 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Edna Hoachlander M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/3/60	
22c. PHYSICIAN'S NAME (Type) Eldon S Hoachlander				22d. ADDRESS Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 4/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 6 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

0732

CERTIFICATE OF DEATH

7338

10

Washington, D.C. 20541
Date of Death: June 12, 1962
Place of Death: Home, 1115
Cause of Death: Heart Disease
Age: 68
Sex: Male
Race: White
Marital Status: Married
Occupation: Retired
Signature: [Illegible]
Date: June 12, 1962
Place: [Illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

07377

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cascade		c. LENGTH OF STAY IN lb 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hawn Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Ellen Last Eyler		4. DATE OF DEATH Month June Day 26 , Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1879
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) New Oxford, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Sadler		14. MOTHER'S MAIDEN NAME Harriet Herman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Kathryn C. Garner		Address 344 S. Potomac, St. Waynesboro, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Cerebrovascular Disease DUE TO 10 years (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 hour			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1960 to June 26, 1960 that I last saw the deceased alive on June 25, 1960 and that death occurred at 6:12 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Thupf		ADDRESS (Street, city or town, state) Blue Ridge Summit, Pa. DATE SIGNED 27 June 60	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 29, 1960	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.	
24a. REC'D BY REGISTRAR JUL 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1933

Washington

District of Columbia

In Case of

James H. H. H. H.

Age 65

Married

One Son

James H. H. H.

None

James H. H. H.

James H. H. H.

James H. H. H.

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James H. H. H.

7440

CERTIFICATE OF DEATH

07378
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN 1b 45 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 29 W. Main St.		d. STREET ADDRESS 29 W. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Washington Last Ferguson		4. DATE OF DEATH Month June Day 15 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1880
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) blacksmith		10b. KIND OF BUSINESS OR INDUSTRY self-employed	
11. BIRTHPLACE (State or foreign country) Ringgold, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. Ferguson		14. MOTHER'S MAIDEN NAME Anna B. Wolfe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-20-1832	
17. INFORMANT Mrs. Nannie M. Ferguson, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 10 Yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/10 , 19 54 , to 6/15 , 19 60 that I last saw the deceased alive on 6/15 , 19 60 , and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 6/16/60			
ACTUAL SIGNATURE Charles F. Hess M.D.			
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		Smithsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6-18-60	22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	22d. LOCATION (City, town, or county) (State) Smithsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

Washington

Salisbury

29 W. Main St.

George

White

Male

Blacksmith

Self-employed

Salisbury, Md.

John H. Ferguson

and R. Wolfe

212-10-1852

Mrs. Natalie L. Ferguson, Salisbury, Md.

no

2-12-50

Salisbury, Maryland

Robert F. Wilson & Son, Salisbury, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07379

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> c. LENGTH OF STAY IN 1b <u>6 miles west on Rt. 40</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6 miles west on Rt. 40</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u> d. STREET ADDRESS <u>1317 S. 4th St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Florig, Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1960</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1934</u>		9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lat operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Mfg.</u>				11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Charles E. Florig</u>						14. MOTHER'S MAIDEN NAME <u>Kathleen Flora</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>186-28-5379</u>				17. INFORMANT <u>Charles E. Florig, 1317 S. 4th, Chambersburg, Pa.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>821X FRACTURED CERVICAL SPINE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u> </div> </div>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>THROWN FROM MOTOR-CYCLE WHILE SPEEDING - HAG. SPEEDWAY</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>2:50</u> o. m. <u>6/12/60</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>SPEEDWAY 6 MI. WEST OF HAGERSTOWN, MD</u>				20f. (City or town) (County) <u>Franklin</u> (State) <u>Pa.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <u>DR. E. W. DITTO, JR.</u>						DATE SIGNED <u>6/12/60</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>				22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pa.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sister-Rouge Funeral Home</u>						24a. REC'D BY REGISTRAR DATE <u>6/12/60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH 6. OCCUPATION 7. MARITAL STATUS 8. COLOR 9. RELIGION 10. EDUCATION 11. PRESENT RESIDENCE 12. DATE OF DEATH 13. TIME OF DEATH 14. PLACE OF DEATH 15. CAUSE OF DEATH 16. MANNER OF DEATH 17. SIGNATURE OF EXAMINER 18. SIGNATURE OF WITNESSES 19. SIGNATURE OF CORONER 20. SIGNATURE OF JURY 21. SIGNATURE OF DISTRICT ATTORNEY 22. SIGNATURE OF CLERK 23. SIGNATURE OF SHERIFF 24. SIGNATURE OF JAILER 25. SIGNATURE OF PRISON WARDEN 26. SIGNATURE OF CHIEF OF POLICE 27. SIGNATURE OF CHIEF OF FIRE DEPARTMENT 28. SIGNATURE OF CHIEF OF SANITARY DEPARTMENT 29. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT 30. SIGNATURE OF CHIEF OF MENTAL HOSPITAL 31. SIGNATURE OF CHIEF OF EYE HOSPITAL 32. SIGNATURE OF CHIEF OF EAR, NOSE AND THROAT HOSPITAL 33. SIGNATURE OF CHIEF OF DENTAL HOSPITAL 34. SIGNATURE OF CHIEF OF DISPENSARY 35. SIGNATURE OF CHIEF OF PHARMACY 36. SIGNATURE OF CHIEF OF LABORATORY 37. SIGNATURE OF CHIEF OF X-RAY DEPARTMENT 38. SIGNATURE OF CHIEF OF RADIOLOGY DEPARTMENT 39. SIGNATURE OF CHIEF OF PATHOLOGY DEPARTMENT 40. SIGNATURE OF CHIEF OF ANATOMY DEPARTMENT 41. SIGNATURE OF CHIEF OF PHYSIOLOGY DEPARTMENT 42. SIGNATURE OF CHIEF OF BOTANY DEPARTMENT 43. SIGNATURE OF CHIEF OF ZOOLOGY DEPARTMENT 44. SIGNATURE OF CHIEF OF AGRICULTURE DEPARTMENT 45. SIGNATURE OF CHIEF OF FISHERIES DEPARTMENT 46. SIGNATURE OF CHIEF OF MINES DEPARTMENT 47. SIGNATURE OF CHIEF OF MANUFACTURES DEPARTMENT 48. SIGNATURE OF CHIEF OF COMMERCE DEPARTMENT 49. SIGNATURE OF CHIEF OF TRANSPORTATION DEPARTMENT 50. SIGNATURE OF CHIEF OF PUBLIC WORKS DEPARTMENT 51. SIGNATURE OF CHIEF OF PUBLIC SAFETY DEPARTMENT 52. SIGNATURE OF CHIEF OF PUBLIC HEALTH DEPARTMENT 53. SIGNATURE OF CHIEF OF PUBLIC INSTRUCTION DEPARTMENT 54. SIGNATURE OF CHIEF OF PUBLIC WELFARE DEPARTMENT 55. SIGNATURE OF CHIEF OF PUBLIC UTILITIES DEPARTMENT 56. SIGNATURE OF CHIEF OF PUBLIC DEFENSE DEPARTMENT 57. SIGNATURE OF CHIEF OF PUBLIC ORDER DEPARTMENT 58. SIGNATURE OF CHIEF OF PUBLIC MORALS DEPARTMENT 59. SIGNATURE OF CHIEF OF PUBLIC RELATIONS DEPARTMENT 60. SIGNATURE OF CHIEF OF PUBLIC INFORMATION DEPARTMENT 61. SIGNATURE OF CHIEF OF PUBLIC AFFAIRS DEPARTMENT 62. SIGNATURE OF CHIEF OF PUBLIC COUNSEL DEPARTMENT 63. SIGNATURE OF CHIEF OF PUBLIC ADVISORY DEPARTMENT 64. SIGNATURE OF CHIEF OF PUBLIC CONSULTANTS DEPARTMENT 65. SIGNATURE OF CHIEF OF PUBLIC ASSISTANTS DEPARTMENT 66. SIGNATURE OF CHIEF OF PUBLIC EMPLOYEES DEPARTMENT 67. SIGNATURE OF CHIEF OF PUBLIC CONTRACTORS DEPARTMENT 68. SIGNATURE OF CHIEF OF PUBLIC SUPPLIERS DEPARTMENT 69. SIGNATURE OF CHIEF OF PUBLIC VENDORS DEPARTMENT 70. SIGNATURE OF CHIEF OF PUBLIC DISTRIBUTORS DEPARTMENT 71. SIGNATURE OF CHIEF OF PUBLIC RETAILERS DEPARTMENT 72. SIGNATURE OF CHIEF OF PUBLIC WHOLESALE DEALERS DEPARTMENT 73. SIGNATURE OF CHIEF OF PUBLIC EXPORTERS DEPARTMENT 74. SIGNATURE OF CHIEF OF PUBLIC IMPORTERS DEPARTMENT 75. SIGNATURE OF CHIEF OF PUBLIC SHIPPERS DEPARTMENT 76. SIGNATURE OF CHIEF OF PUBLIC CARRIERS DEPARTMENT 77. SIGNATURE OF CHIEF OF PUBLIC PASSENGERS DEPARTMENT 78. SIGNATURE OF CHIEF OF PUBLIC FREIGHT DEPARTMENT 79. SIGNATURE OF CHIEF OF PUBLIC PASSENGER DEPARTMENT 80. SIGNATURE OF CHIEF OF PUBLIC MAIL DEPARTMENT 81. SIGNATURE OF CHIEF OF PUBLIC TELEGRAPH DEPARTMENT 82. SIGNATURE OF CHIEF OF PUBLIC TELEPHONE DEPARTMENT 83. SIGNATURE OF CHIEF OF PUBLIC CABLE DEPARTMENT 84. SIGNATURE OF CHIEF OF PUBLIC POST DEPARTMENT 85. SIGNATURE OF CHIEF OF PUBLIC EXPRESS DEPARTMENT 86. SIGNATURE OF CHIEF OF PUBLIC CARRIER DEPARTMENT 87. SIGNATURE OF CHIEF OF PUBLIC MESSENGER DEPARTMENT 88. SIGNATURE OF CHIEF OF PUBLIC COURIER DEPARTMENT 89. SIGNATURE OF CHIEF OF PUBLIC MESSENGER DEPARTMENT 90. SIGNATURE OF CHIEF OF PUBLIC COURIER DEPARTMENT 91. SIGNATURE OF CHIEF OF PUBLIC MESSENGER DEPARTMENT 92. SIGNATURE OF CHIEF OF PUBLIC COURIER DEPARTMENT 93. SIGNATURE OF CHIEF OF PUBLIC MESSENGER DEPARTMENT 94. SIGNATURE OF CHIEF OF PUBLIC COURIER DEPARTMENT 95. SIGNATURE OF CHIEF OF PUBLIC MESSENGER DEPARTMENT 96. SIGNATURE OF CHIEF OF PUBLIC COURIER DEPARTMENT 97. SIGNATURE OF CHIEF OF PUBLIC MESSENGER DEPARTMENT 98. SIGNATURE OF CHIEF OF PUBLIC COURIER DEPARTMENT 99. SIGNATURE OF CHIEF OF PUBLIC MESSENGER DEPARTMENT 100. SIGNATURE OF CHIEF OF PUBLIC COURIER DEPARTMENT</p>		<p>1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH 6. OCCUPATION 7. MARITAL STATUS 8. COLOR 9. RELIGION 10. EDUCATION 11. PRESENT RESIDENCE 12. DATE OF DEATH 13. TIME OF DEATH 14. PLACE OF DEATH 15. CAUSE OF DEATH 16. MANNER OF DEATH 17. SIGNATURE OF EXAMINER 18. SIGNATURE OF WITNESSES 19. SIGNATURE OF CORONER 20. SIGNATURE OF JURY 21. SIGNATURE OF DISTRICT ATTORNEY 22. SIGNATURE OF CLERK 23. SIGNATURE OF SHERIFF 24. SIGNATURE OF JAILER 25. SIGNATURE OF PRISON WARDEN 26. SIGNATURE OF CHIEF OF POLICE 27. SIGNATURE OF CHIEF OF FIRE DEPARTMENT 28. SIGNATURE OF CHIEF OF SANITARY DEPARTMENT 29. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT 30. 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DR. W. L. LITTLE, JR.

7387

CERTIFICATE OF DEATH

Reg. Dist. No.

07380

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leitersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ABNER Last FUNK		4. DATE OF DEATH Month June Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1906
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Houses etc.	
11. BIRTHPLACE (State or foreign country) Strasburg, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Funk		14. MOTHER'S MAIDEN NAME Elizabeth Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 223-20-4153	
17. INFORMANT Mrs. Wm. A. Funk		Address Leitersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA and CONGESTION DUE TO cor Pulmonale decompensated Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. PULMONARY EMPHYSEMA, SEVERE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 10 YRS 15 YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 16 , 19 60 , to JUNE 20 , 19 60 , that I last saw the deceased alive on JUNE 20 , 19 60 , and that death occurred at 7:10 PM , from the causes and on the date stated above.		DATE SIGNED 6-22-60	
ACTUAL SIGNATURE E. R. Lardizabal M.D.		ADDRESS (Street, city or town, state) 12 South Main St	
PHYSICIAN'S NAME (Type) E. R. Lardizabal M.D.		Smithsburg Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 23, 1960	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUN 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

Under a n Assumed name

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED



7397

CENTRAL TELEGRAPH

Washington County, Maryland
June 15, 1910
To the Honorable
Governor of Maryland
Annapolis, Maryland
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the matter of the proposed extension of the Baltimore and Annapolis Electric Railway Company's line from Annapolis to the city of Baltimore.
I am sorry to hear that the proposed extension of the line is not being carried out, and I hope that the company will be able to secure the necessary funds to complete the project.
Very respectfully,
John D. Smith
Secretary of the Board of Public Works

7431

CERTIFICATE OF DEATH

Reg. 101-16

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>K.</u> Last <u>Gearhart</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1876</u>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CEMENT</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagers town, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Martin J. Gearhart</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Welty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Arthur Eyer, 409 S. Potomac St.</u>		Address <u>Waynesboro, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion & Myocardial infarct</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 24, 1960</u> , to <u>June 13, 1960</u> , that I last saw the deceased alive on <u>May 30, 1960</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>ME By Kit</u>		DATE SIGNED <u>6-13-60</u>	
PHYSICIAN'S NAME (Type) <u>ME By Kit</u>		ADDRESS (Street, city or town, state) <u>28 W Potomac</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 16, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Martin Poe</u>		ADDRESS <u>Waynesboro, Penna.</u>	
24a. REC'D BY REGISTRAR <u>JUN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

CERTIFICATE OF DEATH

1951

(M)

Washington

Willington

Willington Sanatorium

Harry

and wife

Convent

Martin P. Convent

Age

Convent

Convent

Convent

Convent

Convent

Convent

Convent

Convent

Convent

Convent

Convent

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
Reg. Dist. No. 302														
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) rear 518 Mitchell Ave					e. STREET ADDRESS 510 Salem Ave			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First JOHN Middle RAYMOND Last GLADHILL					4. DATE OF DEATH Month June Day 7 Year 1960									
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 20 1907		9. AGE (In years last birthday) 52 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME Charles R. Gladhill					14. MOTHER'S MAIDEN NAME Linnie Eyerly									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. W.W#2 214-09-7667					17. INFORMANT Charles R. Gladhill Address 510 Salem Ave Hagerstown, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recent DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .														
ACTUAL SIGNATURE [Signature] M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) Dr E W Dittto Jr					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/9/60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland						
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown, Md					24a. REC'D BY REGISTRAR JUN 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

07382

7388

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2

7389

CERTIFICATE OF DEATH

07384
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 35 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 840 VIRGINIA AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BEATRICE ^{First} IRENE ^{Middle} GRIFFITH ^{Last}		4. DATE OF DEATH JUNE ^{Month} 29 ^{Day} 19 ^{Year} 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/1909
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MILLER		14. MOTHER'S MAIDEN NAME DAISY STITLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
17. INFORMANT MR. HARRY GRIFFITH		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 170X IMMEDIATE CAUSE (a) carcinoma of DUE TO (b) Ca breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year 5 yrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 to June , 1960 , that I last saw the deceased alive on June 27 , 1960 , and that death occurred at 742 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward N. Weeks		ADDRESS (Street, city or town, state) 136 N. Potomac	
PHYSICIAN'S NAME (Type) Howard N. Weeks		DATE SIGNED 6/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/1/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11284

OFFICE OF THE DIRECTOR OF THE BUREAU OF THE ARMY

11284



TO THE DIRECTOR OF THE BUREAU OF THE ARMY
FROM THE DIRECTOR OF THE BUREAU OF THE ARMY
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report.]

APPROVED: [Illegible Signature]
DATE: [Illegible]
[Illegible text at the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7390

CERTIFICATE OF DEATH

07385
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MATYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 10 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1816 GILBERT AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FAY First WILSON Middle GUM Last		4. DATE OF DEATH JUNE Month 22 Day 19 Year 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/ 8/1922
9. AGE (In years last birthday) 37 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH GUM		14. MOTHER'S MAIDEN NAME DORA SWICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) YES (If War, give war and dates of service) W.W.II		16. SOCIAL SECURITY NO. 216-18-1627	
17. INFORMANT MRS. JESSIE B. GUM		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 3 mo + INTERVAL BETWEEN ONSET AND DEATH 7 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4 , 19 60 , to June 15 , 19 60 , that I last saw the deceased alive on June 15 , 19 60 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Lloyd A. Hoffman		ADDRESS (Street, city or town, state) DATE SIGNED 214 N. Potomac St. 6/23/60	
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/24/60	
22c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

W. J. Stewart, Registrar, N.Y.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7391 CERTIFICATE OF DEATH

07386

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWIN First STEPHEN Middle GUTH Last		4. DATE OF DEATH June Month 25 Day 19 60 Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commissioner		10b. KIND OF BUSINESS OR INDUSTRY City Works Board	
11. BIRTHPLACE (State or foreign country) Ironton, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander A. Guth		14. MOTHER'S MAIDEN NAME Sarah Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-6935	
17. INFORMANT Mrs. Sadie C. Guth		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO Unknown (c) Arteriosclerotic Heart Disease DUE TO Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 20, 1953 to June 25, 1960 that (I) (we) last saw the deceased alive on June 25, 1960 , and that death occurred on 10/26/60 from the causes and on the date stated above.			
22a. SIGNATURE L. L. Packer Jr.		22b. DATE SIGNED 6/27/60	
22c. PHYSICIAN'S NAME (Type) L. L. Packer Jr. M.D.		22d. ADDRESS 145 W. Washington St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/1960	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer		25a. REC'D BY REGISTRAR Arthur L. Packer	
ADDRESS Hagerstown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Packer	
DATE JUN 29 '60			

CERTIFICATE OF DEATH

1931

11

Westchester County, New York
 Date of Death: October 2, 1931
 Place of Death: 107 Clinton Ave.
 Age: 78
 Sex: Male
 Race: White
 Birth: [illegible]
 Occupation: [illegible]
 Cause of Death: [illegible]
 Burial: [illegible]
 Registrar: [illegible]
 Date: [illegible]

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7392
CERTIFICATE OF DEATH
07387

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 31 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1224 Pinecrest Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle DELL Last HARVEY				4. DATE OF DEATH Month June Day 15 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Colton, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wyatt				14. MOTHER'S MAIDEN NAME Amanda Mc Quain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 406-38-2156		17. INFORMANT Mr. James C. Hartsaw Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease c 420.0 DUE TO coronary insufficiency & hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes INTERVAL BETWEEN ONSET AND DEATH several years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/18/60 to 6/15/60 , 19 60 , that (I) (we) last saw the deceased alive on 6/15/60 , 19 60 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/17/60	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/18/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 20 '60	
				25b. REGISTRAR'S SIGNATURE William S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M/9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7393

CERTIFICATE OF DEATH

07388

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK 1011.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS WATKINS ACRES APTS.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET SUE HIGUCHI		4. DATE OF DEATH Month Day Year JUNE 17 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/60
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days 1 12	11. IF UNDER 24 HRS. Hours Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KIYOSHI HIGUCHI		14. MOTHER'S MAIDEN NAME THELMA TAKEDA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. KIYOSHI HIGUCHI		18. ADDRESS FREDERICK MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Stalectosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Prematurity 2 hrs 40g DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Toxemia Mente (Chronic Hepatitis)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15/1960 to 6/17/1960 , that I last saw the deceased alive on 6/17/1960 , and that death occurred at 11:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. Bacon		DATE SIGNED 101 King St Hagerstown Md 6/17/60	
PHYSICIAN'S NAME (Type) A. M. Bacon M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6/18/60	
22c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK CREM.		22d. LOCATION (City, town, or county) (State) BALTIMORE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown Md		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

2081381XVI

CERTIFICATE OF DEATH

1937



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Page 4
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
DR. KEADLE
318 N. POTOMAC ST.
HAGERSTOWN

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7394
CERTIFICATE OF DEATH
07389

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>18 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 EAST FIRST STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALVA</u> Middle <u>LUTHER</u> Last <u>HUTZEL</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>MALIE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-4-1881</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATION FURNITURE MFG. CO. FRED. CO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL E. HUTZEL</u>		14. MOTHER'S MAIDEN NAME <u>EMMA McBRIDE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-10-5874</u>	
17. INFORMANT <u>AUSTIN W. HUTZEL</u>		Address <u>825 S. POTOMAC ST. HAGERSTOWN MD. 21</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>36 hours.</u> <u>Indefinite.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour</u> <u>a.m.</u> <u>19</u> <u>p.m.</u>		20d. INJURY OCCURRED <u>While</u> <u>Not while</u> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>February 1959</u> death <u>June 16, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 16, 1960</u> , and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert F. Keadle</u>		22b. DATE <u>June 18, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>		22d. ADDRESS <u>Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE-20-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Best</u>		25a. REC'D BY REGISTRAR <u>JUN 22 '60</u>	
ADDRESS <u>BOONSBORO WASH. CO. MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

12 MONTHS
12 MONTHS
12 MONTHS

CERTIFICATE OF DEATH

1938

1938

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO COUNTRY

1 7442 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07390

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Boonesboro		c. LENGTH OF STAY IN 1b 15½ Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boonesboro Md. #2 Keedy Fahrney Memorial Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Smithsburg	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Harris Ingram		4. DATE OF DEATH Month Day Year June 26, 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1864
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchard owner		10b. KIND OF BUSINESS OR INDUSTRY Luenenburg, Nova Scotia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas W. Ingram		14. MOTHER'S MAIDEN NAME Melissa Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Ray F. Ingram		Address Smithsburg Md., #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191.3 Chronic generalized arteriosclerosis DUE TO (b) Carcinoma of left side of face DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 6 months
21. I certify that I attended the deceased from June 25, 1960, to June 26, 1960, that I last saw the deceased alive on June 25, 1960, and that death occurred at 5:14 P.M. from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE G. W. Heckman		ADDRESS (Street, City or town, state) Boonesboro Md. DATE SIGNED 6/25/60	
PHYSICIAN'S NAME (Type) G. W. Heckman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/60	
22c. NAME OF CEMETERY OR CREMATORY Hillside		22d. LOCATION (City, town, or county) (State) Plainfield N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Z. Gave Wagner, Pa		24a. REC'D BY REGISTRAR DATE JUN 29 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7395

CERTIFICATE OF DEATH

Reg. Dist. No.

07391

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Elsie</u> Last <u>Itneyer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1912</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mail sorter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>near Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Clyde B. Itneyer</u>		14. MOTHER'S MAIDEN NAME <u>Lulu Neff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Nellie Lytton, Hagerstown, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Carcinoma of the uterus, original site</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>17 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>59</u> , to <u>June 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>60</u> , and that death occurred at <u>5:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>148 West Washington St. 6/8/60</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6-10-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 13 '60</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

M

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88

7395

CERTIFICATE OF DEATH

0230

Place

Washington

Residence

Age

1900

Washington County Hospital

Sex

Mar

Occupation

Cause

Method

1915

White

U.S. Army Officer, West

1st

Army

John P. Finney

Mr. William Finney, Washington, D.C.

Finney

1915

1915

1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6266 7-6-60 et

7396

CERTIFICATE OF DEATH

Reg. Dist. No 07392

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 33 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Henry Johnson				4. DATE OF DEATH 6 23 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1872 March 12 1882	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY gardener		11. BIRTHPLACE (State or foreign country) Falling Waters W. Va.	
13. FATHER'S NAME Charles H. Johnson				14. MOTHER'S MAIDEN NAME Tobiasse Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-42-1359		17. INFORMANT Reginald Johnson 125 W Church Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44-6X adrenia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) nefroclerosis & genl arteriosclerosis DUE TO (c) year						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/4/60 , 19__, to 6/23/60 , 19__, that I last saw the deceased alive on 6/23/60 , 19__, and that death occurred at 6 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 N. Potomac St., Hagerstown, Md. DATE SIGNED 6/25/60							
ACTUAL SIGNATURE Howard N. Weeks, M.D.				M.D. 136 N. Potomac St., Hagerstown, Md.			
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-27-1960		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md.				24a. REC'D BY REGISTRAR DATE JUN 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7397

CERTIFICATE OF DEATH

Reg. Dist. No. 07393

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 57 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Allen Keifer		4. DATE OF DEATH Month Day Year June 14 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1883
9. AGE (In years lost birthday) yrs. 77		10. IF UNDER 1 YEAR Months Days Hours Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Industry	
11. BIRTHPLACE (State or foreign country) Cascade Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Cyrus Keifer		14. MOTHER'S MAIDEN NAME Missouri Harbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-4025	
17. INFORMANT Mrs. Minnie M. Keifer		Address Hagerstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma to liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary carcinoma of lung DUE TO (c) 163X		INTERVAL BETWEEN ONSET AND DEATH 2 months months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enlarged arteriosclerotic abdominal aortic aneurysm		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26, 1960 to June 14, 1960 , that I last saw the deceased alive on June 13, 1960 , and that death occurred at 6:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 S. Prospect, Hagerstown, Md.			
ACTUAL SIGNATURE John C. Stauffer		DATE SIGNED 6/14/60	
PHYSICIAN'S NAME (Type) John C. Stauffer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1960	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR JUN 17 '60	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

41

CERTIFICATE OF DEATH

383

717 Virginia Ave.

Chicago, Ill.

January 11, 1933

Chicago, Ill.

Missouri, U.S.A.

Chicago, Ill.

11-3-1933

During existence of body
interstate commerce to land

Transfer interstate commerce with company

April 26, 1933

John J. Hoff

June 10, 1933

County of Winnebago, State of Wisconsin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
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7398

07394

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 55 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD First DAVIS Middle KERFOOT Last		4. DATE OF DEATH Month June Day 28 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yard Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Washington Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Jacob Kerfoot		14. MOTHER'S MAIDEN NAME Anna E. Arthur	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-5023	
17. INFORMANT Robert Kerfoot		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death by ventricular failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive - arteriosclerotic Heart Disease DUE TO (c) Unknown many years		INTERVAL BETWEEN ONSET AND DEATH few minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-1-1950 to 6/28-1960 that (I) (we) last saw the deceased alive on 6/28-1960 and that death occurred at 3:15 P.M. on the causes and on the date stated above.			
22a. SIGNATURE John H. Hornbaker		22b. DATE SIGNED 6:29:60	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 West Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/1/1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Houzer Funeral Home R. Shuman		25a. REC'D BY REGISTRAR JUL 5 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

2967

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Journal of Management Inquiry 18(1) 3-15

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M
DR. RALPH YOUNG
WILLIAMSBURG MD

37399
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07396

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>40 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>838 FREDERICK ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. AGE OF DECEASED (Type or print) First <u>BERTIE</u> Middle <u>LARUE</u> Last <u>LANTZ</u>				4. DATE OF DEATH Month <u>JUNE</u> - Day <u>8</u> - Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 3, 1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HANOVER PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM YANTIS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET YANTIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FRANK TANGER</u> Address <u>838 FREDERICK ST. HAGERSTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CC - Myocardial infarction Immediate</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>6/7/60</u> (County) <u>6/8/60</u> (State) <u>19</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>6/7/60</u> to <u>6/8/60</u> , that (I) (we) last saw the deceased alive on <u>6/8/60</u> , and that death occurred at <u>6/9/60</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph Young</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/9/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph Young</u>				22d. ADDRESS <u>Boonsboro MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 11, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				25a. REC'D BY REGISTRAR <u>DATE JUN 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

7432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Berkeley ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg, Route # 2 RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium				d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jacob Henry Lingamfelter				4. DATE OF DEATH Month Day Year June 28 1960			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1882		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Charles Lingamfelter				14. MOTHER'S MAIDEN NAME Annabell Small			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT		Address Mrs. W. Hoge Light ,Martinsburg, Rt 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (First stroke July 10, 1957- (c) Chronic Interstitial Nephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs.							INTERVAL BETWEEN ONSET AND DEATH 3 wks 5 yrs 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1957 , to June 28, 1960 , that I last saw the deceased alive on June 28, 1960 , and that death occurred at 5:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Victor L. Glover		M.D. 407 W. King St Martinsburg, W. Va		ADDRESS (Street, city or town, state) 6-28		DATE SIGNED V. L. G.	
PHYSICIAN'S NAME (Type) VICTOR L. GLOVER, M.D.		MARTINSBURG		W. Va			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1960		22c. NAME OF CEMETERY OR CREMATORY West Alexander Cemetery		22d. LOCATION (City, town, or county) (State) West Alexander, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf Williamsport		ADDRESS Ynd.		24a. REC'D BY REGISTRAR JUL 1 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kneass	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

10780

CERTIFICATE OF DEATH

1930



MASTERS, JAMES DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. Name of deceased: JAMES MASTERS

2. Date of death: JANUARY 15, 1930

3. Place of death: 1234 E. BALTIMORE ST.

4. Cause of death: HEART DISEASE

5. Age at death: 45 years

6. Sex: Male

7. Race: White

8. Occupation: Clerk

9. Signature of physician: J. H. SMITH

10. Signature of registrar: J. H. SMITH

7433
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Wesley</u> Last <u>Lizer</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1877</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boatsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canal</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Lizer</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		INFORMANT Address <u>George S. Lizer (Son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Diffuse Arteriosclerosis</u> DUE TO (c) <u>2 days</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Williamsport</u> <u>Md.</u>		
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>Sept 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 2</u> , 19 <u>60</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M E Byrkit</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>28 W Potomac</u> <u>6-3-60</u>					
PHYSICIAN'S NAME (Type) <u>M E Byrkit</u>		<u>Williamsport Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md</u>				ADDRESS <u>Williamsport, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

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Page 4 after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

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CERTIFICATE OF DEATH

1933

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

Official Use Only
Illinois State Department of Health
Chicago, Illinois

7400

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 17 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 333 S. Mulberry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLIS Middle PORTER Last LYNCH				4. DATE OF DEATH Month June Day 27 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1896		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft		11. BIRTHPLACE (State or foreign country) Fulton County, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Biddis Lynch				14. MOTHER'S MAIDEN NAME Della Gordon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-2765		INFORMANT Address Mrs. E. P. Lynch 333 S. Mulberry St. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) general arteriosclerosis and cerebral DUE TO (c) arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2-4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① chr. pancreatitis ② Healed gastric ulcer ③ prostate hypertrophy							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1959 , to June 27, 1960 , that I last saw the deceased alive on June 27, 1960 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto III , M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 217 West Washington Street 6/28/60			
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7401

CERTIFICATE OF DEATH

07400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 6 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 321 S. CANNON AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY PRUDENCE MAGAHA				4. DATE OF DEATH JUNE 23 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/1880	
9. AGE (In years lost birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS BRASHEARS				14. MOTHER'S MAIDEN NAME SARAH PETERMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS EVA CHURCHEY HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 432.1 DUE TO cardiovascular collapse Arteriosclerotic Gen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15 , 19 60 , to 6/23 , 19 60 and that death occurred at 6:08 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Antietam Hagerstown, Md. DATE SIGNED 6/24/60							
ACTUAL SIGNATURE L. J. Thompson M.D.				PHYSICIAN'S NAME (Type) Louis G. Gross M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/26/60		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		22d. LOCATION (City, town, or county) (State) FERDERICK MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE JUN 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

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CERTIFICATE OF DEATH

1925

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

Handwritten notes:
The above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths for the City and County of New York, on the 1st day of January, 1925.

Handwritten notes:
The above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths for the City and County of New York, on the 1st day of January, 1925.

7443

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

07401

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA COUNTY BERKELEY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) INWOOD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GATEWAY NURSING HOME		d. STREET ADDRESS Rt. # 1	
3. NAME OF DECEASED (Type or print) First ELLA Middle MAE Last MASTERS		4. DATE OF DEATH Month JUNE Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 2 Days 24 Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Berkeley Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph Parkinson		14. MOTHER'S MAIDEN NAME Emily Katherine Shade	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT J. D. Masters		Address Inwood, Rt. # 1, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Endocarditis DUE TO Caudilions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Articular Rheumatism DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Pulmonary Tuberculosis - arrested		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1958 to June 21, 1960 , that (I) (we) last saw the deceased alive on June 21, 1960 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Glover, M.D.		22b. DATE SIGNED June 23, 1960	
22c. PHYSICIAN'S NAME (Type) VICTOR L. GLOVER, M.D.		22d. ADDRESS 404 WEST KING ST MARTINSBURG, W. VA	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-1960	
23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION (City, town, or county) (State) Martinsburg, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		25a. REC'D BY REGISTRAR DATE JUN 27 '60	
ADDRESS Martinsburg, W. Va.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS

1963

FABRICATION

WEST VIRGINIA

LEGATARY

(THURSDAY) BIRMINGHAM

5 months

(FUND)

WOOD

CATHOLIC WEDDING HOME

RE. 4.1

x

60

21

JUNE

1. STONE

MAY

ELIA

Female

x

18.1

22

28

House Duties

Home

Harley Co., W. Va. U.S.A.

John P. Johnson

Emily Katherine Shinde

No

J. D. Masters

Wood, Rt. 1, W. Va.

2:30 A.

Serial 6-21-1960

Monter's Cemetery

West Virginia

John P. Brown

Marlinburg, W. Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>12 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALVEY LEE MAYHUGH</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 24 - 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-2-1896</u>	9. AGE (In years last birthday) <u>64 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min. <u>1 22</u>	11. IF UNDER 24 HRS. <u>1 22</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MACHINIST VICTOR PRODUCTS CORP</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BOONSBORO WASH. CO. MD.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HARRY MAYHUGH</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA HOOVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>230-18-1026</u>			
17. INFORMANT <u>MRS. EDNA MAYHUGH</u>				Address <u>BOONSBORO MD. R.1</u>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thick Throated Cancerous Block</u> DUE TO <u>181.0</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/60</u> to <u>6/24/60</u> that (I) (we) last saw the deceased alive on <u>6/13/60</u> and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph F. Young</u>				22b. DATE <u>6/24/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>RALPH F. YOUNG</u>				22d. ADDRESS <u>WILLIAMSPORT MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JUNE 27 1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASH. CO. MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Rad</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 28 '60</u>			
ADDRESS <u>BOONSBORO MD.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1905

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR

Dr. J. J. [illegible]

1/13/05
1/13/05
1/13/05

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07403

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Gloucester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b D. O. A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital D.O.A		d. STREET ADDRESS 803 Broadway	
3. NAME OF DECEASED (Type or print) Douglas Gary Merriell		4. DATE OF DEATH Month June Day 6 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Feb. 27 1960	9. AGE (In years last birthday) 3 yrs. 11 Months 11 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Woodbury N. J.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wallace Merriell		14. MOTHER'S MAIDEN NAME Joan Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Wallace Merriell		Address 803 Broadway Westville N. J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 924.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Placed in crib - face down - face became entangled in plastic bag at bottom of carriage			
20c. TIME OF INJURY Month, Day, Year 11:15 a.m. 6 6 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) nr. Williamsport Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Dittus		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Dittus, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9-60	
22c. NAME OF CEMETERY OR CREMATORY Eglinton Cemetery		22d. LOCATION (City, town, or county) (State) Clarksboro N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md		24a. REC'D BY REGISTRAR DATE JUN 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

21

2

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FOR STATE
HEALTH DEPT

7405

Washington

Lawrence, M. A.

Washington County, Maryland

Douglas

Wentfall

Wife: Alice

Feb. 27 1960

3 11

Home

Lockhart, H. L.

U.S.A.

Mrs. Wentfall

John Turner

Bone

Mrs. Wentfall

803 Broadway
Baltimore, Md.

1960

Completed by: [illegible]
Date: [illegible]
All rights reserved.

RECEIVED: [illegible]

RECEIVED: [illegible]

RECEIVED: [illegible]

RECEIVED: [illegible]

RECEIVED: [illegible]

RECEIVED: [illegible]

Washington County

Chapman, J. J.

RECEIVED: [illegible]

1
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07404

7404

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 22 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 413 George Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First CHALICE Middle MILLER Last		4. DATE OF DEATH June Month 26 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 16, 1895
9. AGE (In years lost birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooks Helper		10b. KIND OF BUSINESS OR INDUSTRY Restraunt	
11. BIRTHPLACE (State or foreign country) Franklin Co., Penn. 1/2		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Miller		14. MOTHER'S MAIDEN NAME Linnie Holsinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 188-09-5447H	
17. INFORMANT Mrs. Virgie Daley		Address Shady Grove, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure due to DUE TO Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4-20-0 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma and Emphysema.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1960 to June 26, 1960 that (I) (we) last saw the deceased alive on 6-26-1960 , and that death occurred at 8P.M. from the causes and on the date stated above.			
22a. SIGNATURE R. A. Bell		22b. DATE SIGNED June 29, 1960	
22c. PHYSICIAN'S NAME (Type) R. A. Bell, M. D.		22d. ADDRESS Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/29/1960	
23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City, town, or county) (State) Waynesboro, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		25a. REC'D BY REGISTRAR Hagerstown, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus		DATE JUN 29 '60	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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2007, 1st Edition

2027

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07405

7405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY ONONDAGA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYRACUSE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 532 NORTH SALINA STREET			
3. NAME OF DECEASED (Type or print) First ANTOINETTE Middle NASTRI Last NASTRI				4. DATE OF DEATH Month JUNE Day 16 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 16 1884		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILORING		10b. KIND OF BUSINESS OR INDUSTRY SUIT MANUFACTORS		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? DIMASI				14. MOTHER'S MAIDEN NAME ELIZABETH ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT EDMUND NASTRI 244 HARDING ST SYRACUSE N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute subdural and DUE TO Subarachnoid Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 446 (c) 446						INTERVAL BETWEEN ONSET AND DEATH about	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) multiple body contusions multiple fractured ribs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was thrown from auto in accident					
20c. TIME OF INJURY Month, Day, Year 6 14 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Mr. Frederick, Fred. Rd	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Edward W. Dittus III				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/17/60	
EXAMINER'S NAME (Type) E W DITTO III				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 6/17/60		22c. NAME OF CEMETERY OR CREMATORY ASSUMPTION CEMETERY		22d. LOCATION (City, town, or county) (State) SYRACUSE NEW YORK	
23. SUPERVISOR'S NAME Charles M. KOUZER				ADDRESS HAGERSTOWN MARYLAND		24a. REC'D BY REGISTRAR JUN 20 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARTIN STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		BIRTH DATE [REDACTED]		BIRTH PLACE [REDACTED]	
OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]		EDUCATION [REDACTED]	
PRESENT ADDRESS [REDACTED]		US BIRTH RECORD NO. [REDACTED]		SOCIAL SECURITY NO. [REDACTED]	
DECEASED ADDRESS [REDACTED]		DECEASED CITY [REDACTED]		DECEASED STATE [REDACTED]	
DECEASED COUNTY [REDACTED]		DECEASED ZIP CODE [REDACTED]		DECEASED COUNTRY [REDACTED]	
DECEASED DATE OF BIRTH [REDACTED]		DECEASED TIME OF BIRTH [REDACTED]		DECEASED PLACE OF BIRTH [REDACTED]	
DECEASED TIME OF DEATH [REDACTED]		DECEASED PLACE OF DEATH [REDACTED]		DECEASED COUNTRY OF DEATH [REDACTED]	
DECEASED CAUSE OF DEATH [REDACTED]		DECEASED MANNER OF DEATH [REDACTED]		DECEASED MEDICAL HISTORY [REDACTED]	
DECEASED PHYSICIAN [REDACTED]		DECEASED HOSPITAL [REDACTED]		DECEASED CITY [REDACTED]	
DECEASED STATE [REDACTED]		DECEASED COUNTY [REDACTED]		DECEASED ZIP CODE [REDACTED]	
DECEASED COUNTRY [REDACTED]		DECEASED DATE OF DEATH [REDACTED]		DECEASED TIME OF DEATH [REDACTED]	
DECEASED PLACE OF DEATH [REDACTED]		DECEASED COUNTRY OF DEATH [REDACTED]		DECEASED MEDICAL HISTORY [REDACTED]	
DECEASED PHYSICIAN [REDACTED]		DECEASED HOSPITAL [REDACTED]		DECEASED CITY [REDACTED]	
DECEASED STATE [REDACTED]		DECEASED COUNTY [REDACTED]		DECEASED ZIP CODE [REDACTED]	
DECEASED COUNTRY [REDACTED]		DECEASED DATE OF DEATH [REDACTED]		DECEASED TIME OF DEATH [REDACTED]	
DECEASED PLACE OF DEATH [REDACTED]		DECEASED COUNTRY OF DEATH [REDACTED]		DECEASED MEDICAL HISTORY [REDACTED]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MORTUARY ACT, CHAPTER 10, SECTION 101, OF THE MARYLAND CODE, TITLE 10, SUBTITLE 1, AND FOR THE PURPOSES OF THE MORTUARY ACT, CHAPTER 10, SECTION 102, OF THE MARYLAND CODE, TITLE 10, SUBTITLE 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07406

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAPLAND RURAL</u>				c. LENGTH OF STAY IN 1b <u>38 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GAPLAND MD.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE EDWARD NORRIS</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 20 - 19 60</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH, 20, 1889</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>TREGO WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GEORGE E. NORRIS</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN GLOSS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-30-9374</u>		17. INFORMANT Address <u>MRS. NANNIE NORRIS - GAPLAND MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1960</u> to <u>June 20, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 17, 1960</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. LeVan</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>	
22d. ADDRESS <u>Boonsboro, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 24, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VIEW CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BURKETTSVILLE FRED. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Post</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07407

7406

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 12 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON CO. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle VIRGINIA Last OREN		4. DATE OF DEATH Month JUNE Day 25 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME JEREMIAH STILL		14. MOTHER'S MAIDEN NAME MARY McCORMICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerosis Gen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO Myocardial Enlargement (c) Myocardial Enlargement		INTERVAL BETWEEN ONSET AND DEATH hrs 4 min 24	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hernia Fem - obstructive Small Intest			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 24 , 19 60 to June 25 , 19 60 , that I last saw the deceased alive on June 24 , 19 60 , and that death occurred at 119 E. Antietam , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6/27/60 ACTUAL SIGNATURE Louis G. Gratt M.D. PHYSICIAN'S NAME (Type) Louis G. Gratt Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/29/60	
22c. NAME OF CEMETERY OR CREMATORY THREE CHURCH HILL CEM.		22d. LOCATION (City, town, or county) (State) MATINS CREEK PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1900

CENTRAL OF DEATH

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[Faint, illegible handwritten text, possibly a letter or report, covering the lower half of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07408

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>ELEVEN YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1004 SALEM AVENUE</u>				d. STREET ADDRESS <u>1004 SALEM AVENUE</u>			
3. NAME OF DECEASED (Type or print) First <u>ALDINE</u> Middle <u>D</u> Last <u>PALMER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>-18-</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY-17-1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR - HAGERSTOWN SHOE CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NEAR MYERSVILLE FRED. CO</u>		11. BIRTHPLACE (State or foreign country) <u>MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>MD. U.S.A.</u>							
13. FATHER'S NAME <u>EDWARD PALMER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E. KOOGLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-09-5783</u>		17. INFORMANT <u>MRS. NAOMI PALMER</u> Address <u>1004 SALEM AVE. HAGERSTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gunshot wound Head</u> DUE TO <u>9776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> <u>Hypertension</u> <u>Depressive Reaction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted wound at temporal area</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>4:30</u> p. m. <u>6 20 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/20/60</u>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M. D. Act</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 21, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Best</u>		ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

7408

7408

CERTIFICATE OF DEATH

07409

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		c. LENGTH OF STAY IN 1b 30 YEARS		d. STREET ADDRESS 38 N. POTOMAC ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HELEN I. PHELPS		First Middle Last		4. DATE OF DEATH Month Day Year 6 24 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 30, 1905		9. AGE (In years last birthday) yrs. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME EDWARD J. HEEFNER			14. MOTHER'S MAIDEN NAME ANNIE M. ODEN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 161-12-0444		17. INFORMANT Address MRS. MARY GEIST III 4 S. POTOMAC ST. HAGERSTOWN, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic CARCINOMA of Lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of Breast, Rt. DUE TO (c) 170X					INTERVAL BETWEEN ONSET AND DEATH 2 mo. 1 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 9, 1959 to June 24, 1960 , that (I) (we) last saw the deceased alive on June 23, 1960 , and that death occurred at 320A M, from the causes and on the date stated above.					
22a. SIGNATURE Richard V. Hauver		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 24, 1960	
22c. PHYSICIAN'S NAME (Type) RICHARD V. HAUVER		22d. ADDRESS 247 N. POTOMAC ST. HAGERSTOWN, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/27/1960		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL	
23d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS		ADDRESS HAGERSTOWN, MD.		25a. REC'D BY REGISTRAR DATE JUN 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

44-25-230

• **1997** • **1998** • **1999** • **2000** • **2001** • **2002** • **2003** • **2004** • **2005** • **2006** • **2007** • **2008** • **2009** • **2010** • **2011** • **2012** • **2013** • **2014** • **2015** • **2016** • **2017** • **2018** • **2019** • **2020** • **2021** • **2022** • **2023** • **2024** • **2025** • **2026** • **2027** • **2028** • **2029** • **2030** • **2031** • **2032** • **2033** • **2034** • **2035** • **2036** • **2037** • **2038** • **2039** • **2040** • **2041** • **2042** • **2043** • **2044** • **2045** • **2046** • **2047** • **2048** • **2049** • **2050** • **2051** • **2052** • **2053** • **2054** • **2055** • **2056** • **2057** • **2058** • **2059** • **2060** • **2061** • **2062** • **2063** • **2064** • **2065** • **2066** • **2067** • **2068** • **2069** • **2070** • **2071** • **2072** • **2073** • **2074** • **2075** • **2076** • **2077** • **2078** • **2079** • **2080** • **2081** • **2082** • **2083** • **2084** • **2085** • **2086** • **2087** • **2088** • **2089** • **2090** • **2091** • **2092** • **2093** • **2094** • **2095** • **2096** • **2097** • **2098** • **2099** • **2100** • **2101** • **2102** • **2103** • **2104** • **2105** • **2106** • **2107** • **2108** • **2109** • **2110** • **2111** • **2112** • **2113** • **2114** • **2115** • **2116** • **2117** • **2118** • **2119** • **2120** • **2121** • **2122** • **2123** • **2124** • **2125** • **2126** • **2127** • **2128** • **2129** • **2130** • **2131** • **2132** • **2133** • **2134** • **2135** • **2136** • **2137** • **2138** • **2139** • **2140** • **2141** • **2142** • **2143** • **2144** • **2145** • **2146** • **2147** • **2148** • **2149** • **2150** • **2151** • **2152** • **2153** • **2154** • **2155** • **2156** • **2157** • **2158** • **2159** • **2160** • **2161** • **2162** • **2163** • **2164** • **2165** • **2166** • **2167** • **2168** • **2169** • **2170** • **2171** • **2172** • **2173** • **2174** • **2175** • **2176** • **2177** • **2178** • **2179** • **2180** • **2181** • **2182** • **2183** • **2184** • **2185** • **2186** • **2187** • **2188** • **2189** • **2190** • **2191** • **2192** • **2193** • **2194** • **2195** • **2196** • **2197** • **2198** • **2199** • **2200** • **2201** • **2202** • **2203** • **2204** • **2205** • **2206** • **2207** • **2208** • **2209** • **2210** • **2211** • **2212** • **2213** • **2214** • **2215** • **2216** • **2217** • **2218** • **2219** • **2220** • **2221** • **2222** • **2223** • **2224** • **2225** • **2226** • **2227** • **2228** • **2229** • **2230** • **2231** • **2232** • **2233** • **2234** • **2235** • **2236** • **2237** • **2238** • **2239** • **2240** • **2241** • **2242** • **2243** • **2244** • **2245** • **2246** • **2247** • **2248** • **2249** • **2250** • **2251** • **2252** • **2253** • **2254** • **2255** • **2256** • **2257** • **2258** • **2259** • **2260** • **2261** • **2262** • **2263** • **2264** • **2265** • **2266** • **2267** • **2268** • **2269** • **2270** • **2271** • **2272** • **2273** • **2274** • **2275** • **2276** • **2277** • **2278** • **2279** • **2280** • **2281** • **2282** • **2283** • **2284** • **2285** • **2286** • **2287** • **2288** • **2289** • **2290** • **2291** • **2292** • **2293** • **2294** • **2295** • **2296** • **2297** • **2298** • **2299** • **2300** • **2301** • **2302** • **2303** • **2304** • **2305** • **2306** • **2307** • **2308** • **2309** • **2310** • **2311** • **2312** • **2313** • **2314** • **2315** • **2316** • **2317** • **2318** • **2319** • **2320** • **2321** • **2322** • **2323** • **2324** • **2325** • **2326** • **2327** • **2328** • **2329** • **2330** • **2331** • **2332** • **2333** • **2334** • **2335** • **2336** • **2337** • **2338** • **2339** • **2340** • **2341** • **2342** • **2343** • **2344** • **2345** • **2346** • **2347** • **2348** • **2349** • **2350** • **2351** • **2352** • **2353** • **2354** • **2355** • **2356** • **2357** • **2358** • **2359** • **2360** • **2361** • **2362** • **2363** • **2364** • **2365** • **2366** • **2367** • **2368** • <

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 7409
 CERTIFICATE OF DEATH
 07410

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Sharpsburg			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Ada Colbert Poffenberger				4. DATE OF DEATH Month Day Year June 28 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days 3 16		IF UNDER 24 HRS. Hours Min. 3 16			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Knotts Quarry W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Benjamin Colbert				14. MOTHER'S MAIDEN NAME Anna Grey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Thomas R. Poffenberger		Address Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection left Kidney DUE TO Thrombosis left Renal Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) 7 days							INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility -							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 20 June 1960 to 27 June 1960 that (I) (we) last saw the deceased alive on 27 June 1960 and that death occurred at 3 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Frank E Brumback				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frank E Brumback				22d. ADDRESS 170 west Washington St			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 1-60		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Donald Butler				25a. REC'D BY REGISTRAR JUL 5 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1905

1905

Washington	Washington	Washington	Washington	Washington	Washington	Washington	Washington	Washington	Washington
3 days	3 days	3 days	3 days	3 days	3 days	3 days	3 days	3 days	3 days
Washington	Washington	Washington	Washington	Washington	Washington	Washington	Washington	Washington	Washington
Goldberg	Goldberg	Goldberg	Goldberg	Goldberg	Goldberg	Goldberg	Goldberg	Goldberg	Goldberg
June 28	June 28	June 28	June 28	June 28	June 28	June 28	June 28	June 28	June 28
1888	1888	1888	1888	1888	1888	1888	1888	1888	1888
None	None	None	None	None	None	None	None	None	None
Anna Gray	Anna Gray	Anna Gray	Anna Gray	Anna Gray	Anna Gray	Anna Gray	Anna Gray	Anna Gray	Anna Gray
None	None	None	None	None	None	None	None	None	None

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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7410

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07411

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 25 YRS. d. NAME OF HOSPITAL (If not in hospital, give street address) WESTERN MD. STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 03 d. STREET ADDRESS 214 SUMMIT AVE. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Millard First Guy Middle Poole Last 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8/12/1895 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH 6 Month 14 Day 1960 Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OPERATOR 10b. KIND OF BUSINESS OR INDUSTRY SERVICE STATION 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ABRAHAM L. POOLE 14. MOTHER'S MAIDEN NAME MAMIE TOMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-09-7172 17. INFORMANT MR. ROY POOLE Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Hypertrophied heart with generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 180X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 1/4 hours 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Broncho pneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 8, 1960 to June 14, 1960 , that (I) (we) last saw the deceased alive on June 14, 1960 and that death occurred at 4:10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Young E. Chun		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/16/60	
23c. NAME OF CEMETERY OR CREMATORY REFORMED CHURCH CEM.		23d. LOCATION (City, town, or county) (State) MIDDLETOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Kline			

03111

WARRANT OF CAPTIVITY OF HEALTH
OFFICE OF THE ATTORNEY GENERAL
STATE OF CALIFORNIA

1910

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. DR. HIRSHMAN

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81

159-W. WASH. ST. HAGERSTOWN, MD.

7411

7411

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07412

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. BRIER - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>T</u> Last <u>REESE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 28 - 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOLS</u>			
11. BIRTHPLACE (State or foreign country) <u>MT. LEAH WASH. CO. MD. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>EZRA REESE</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA ARNOLD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-20-824</u>			
17. INFORMANT <u>MRS. ELSIE M. REESE</u>				Address <u>KEEDYSVILLE MD R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420-0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>arteriosclerotic disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>17 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7</u> 19 <u>55</u> to <u>June 27</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>June 27</u> 19 <u>60</u> , and that death occurred at <u>724</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip J. Hirshman</u>				22b. DATE <u>6/28/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>				22d. ADDRESS <u>159 W. Washington St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July-1-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				25a. REC'D BY REGISTRAR <u>JUL 5 '60</u>			
ADDRESS <u>BOONSBORO MD.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>			

STATE OF NEW YORK
COUNTY OF ALBANY
JANUARY 10, 1901

22

1
TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
7412
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07413
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLSWORTH ROHRBACK ROULETTE		4. DATE OF DEATH June 16, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR 69 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President, Nicodemus		10b. KIND OF BUSINESS OR INDUSTRY Bank	
11. BIRTHPLACE (State or foreign country) Sharpsburg Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Roulette		14. MOTHER'S MAIDEN NAME Annie Rohrback	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-2818	
17. INFORMANT Robert E. Roulette, Hagerstown R#3 Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None.		INTERVAL BETWEEN ONSET AND DEATH 5 hours. Years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 16, 1960 , to June 16, 1960 , that (I) (we) last saw the deceased alive on June 16, 1960 , and that death occurred at 6 A M, from the causes and on the date stated above.			
22a. SIGNATURE R. A. Bell		22b. DATE SIGNED June 18, 1960	
22c. PHYSICIAN'S NAME (Type) R. A. Bell, M.D.		22d. ADDRESS Hagerstown, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md		25. REC'D BY REGISTRAR JUN 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hana			

CERTIFICATE OF DEATH

1913

Washington, D.C.

in the city of Washington, D.C.

on the 15th day of

1913

at the age of 30 years

of the County of Washington, D.C.

John Doe

1913-1914

1913-1914

1913-1914

1913-1914

1913-1914

1913-1914

1913-1914

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7413

CERTIFICATE OF DEATH

07414

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN MD.</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MD. STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna Elizabeth</u> Middle <u>Russler</u> Last <u>Russler</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY-31-1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>28</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL MEREDITH</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE FLOOK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>JOHN T. RUSSLER</u>		Address <u>BOONSBORO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular pneumonia, bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinomatosis</u> DUE TO (c) <u>carcinoma of the breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u> <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1960</u> to <u>June 28, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1960</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos,</u>		22b. DATE SIGNED <u>June 28, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>		22d. ADDRESS <u>Western Md. State Hospital, Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 30, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		25a. REC'D BY REGISTRAR <u>JUL 5 '60</u>	
ADDRESS <u>BOONSBORO MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

1951

CENTRAL OF TEXAS

1951

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 07415										
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Williamsport			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) rear of 615 Elizabeth Ave.					d. STREET ADDRESS Route 2					
3. NAME OF DECEASED (Type or print) First Richard Middle --- Last St. Clair					4. DATE OF DEATH Month June Day 19 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 27, 1926		9. AGE (In years last birthday) 33 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crator		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Hagerstown Md.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Oscar St. Clair				14. MOTHER'S MAIDEN NAME Ruth Cave						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.11 220-18-3288		17. INFORMANT Address Mrs. Ruth V. St. Clair Williamsport Tr. 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 921.5 DUE TO Respiratory vomitus Conditions, if any, which gave rise to immediate cause (b) Acute alcoholic intoxication (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ac. Alcohol intoxication - lay on back seat of car - vomited and aspirated vomitus						
20c. TIME OF INJURY Month, Day, Year Hour 6 19 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. Williamsport		20f. (City or town) (County) (State) Hagerstown Wash Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Edward W. Ditto III M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Edward W. Ditto III					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 6-21-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son					ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7414

CERTIFICATE OF DEATH

Reg. Dist. No.

07416

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle R Last Schaeffer				4. DATE OF DEATH Month June Day 10 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Confectionery Store		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob W. Schaeffer				14. MOTHER'S MAIDEN NAME Sarah Reeder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 186-28-2737		17. INFORMANT Mrs. Neadia P. Schaeffer, 306 W. Main St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum cell sarcoma, retroperitoneal 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 18 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 , to June 10, 1960 , that I last saw the deceased alive on June 10, 1960 , and that death occurred at 11 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. C. Brewer				ADDRESS (Street, city or town, state) 359 E. Baltimore St.			
PHYSICIAN'S NAME (Type) W. C. Brewer, M. D.				DATE SIGNED 6/11/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 13, 1960		22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Waynesboro Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE S. Marlin Poe				ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR DATE JUN 14 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7415
CERTIFICATE OF DEATH

07417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 40 YRS. d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 1 276 S. POTOMAC ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL First MONROE Middle SHAFFER Last		4. DATE OF DEATH Month JUNE Day 6 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING REPAIR CO.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. H. SHAFFER		14. MOTHER'S MAIDEN NAME PHIANNA RHODES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-2794A	
17. INFORMANT MRS. DOROTHY SHAFFER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 days 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 2 , 19 60 to June 6 , 19 60 , that I last saw the deceased alive on June 5 , 19 60 , and that death occurred at 12:45am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. 6/8/60 DATE SIGNED ACTUAL SIGNATURE W. T. Layman M.D. PHYSICIAN'S NAME (Type) W. T. Layman, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, EMBOWAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	6/8/60	ROSE HILL CEM.	HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. T. Layman, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 10 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hester

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Page 4
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/58

1
7416
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7416
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07418

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 8 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Debra Middle Lee Last Shank				4. DATE OF DEATH Month June Day 1 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1 1960	
9. AGE (In years last birthday) yrs. 8		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown Md.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Dale Lee Shank				14. MOTHER'S MAIDEN NAME Betty Maugans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Dale Lee Shank Hagerstown Md RFD #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO 325.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mongolism & congenital defect DUE TO of heart (c) of heart						INTERVAL BETWEEN ONSET AND DEATH 8 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Smithsburg, Md.				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-1-1960 to 6-1-1960 , that (I) (we) last saw the deceased alive on 6-1-1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Charles F. Hess				22b. DATE SIGNED June 6 1960			
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.				22d. ADDRESS Smithsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 3-60		23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md				25a. REC'D BY REGISTRAR DATE JUN 6 1960		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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CERTIFICATE OF DEATH

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Washington County, Maryland

June 1 1913

June 1 1913

Washington County, Maryland

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07420

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 2 Hancock Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS Rural 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thornton John Shoemaker		4. DATE OF DEATH Month Day Year 6 1 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.8.1883
9. AGE (In years lost birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor	
11. BIRTHPLACE (State or foreign country) Washington County Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Shoemaker		14. MOTHER'S MAIDEN NAME Catherine McCarty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-9446	
17. INFORMANT Mrs Leathia Shoemaker Rural 2 Hancock Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Bronchial Pneumonia Lacerating Stomach Juvenile		INTERVAL BETWEEN ONSET AND DEATH 4 da 14 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/25/60 to 6/1/60, that (I) (we) last saw the deceased alive on 6/1/60, and that death occurred at PA from the causes and on the date stated above.			
22a. SIGNATURE L M SHAFER		22b. DATE SIGNED JUN 7 '60	
22c. PHYSICIAN'S NAME (Type) L M SHAFER		22d. ADDRESS Hancock, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6.4.60	
23c. NAME OF CEMETERY OR CREMATORY Stone Bridge Brethern		23d. LOCATION (City, town, or county) (State) Rural Hancock Washington Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone Hancock Md		25a. REC'D BY REGISTRAR DATE JUN 7 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Harris			

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. SECONDARY

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7427

07421

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDER NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARLAN WINFIELD SMITH</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 12, 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL - 8 - 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. C. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED POLICEMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CITY PARK</u>			
13. FATHER'S NAME <u>OTH O WESLEY</u>				14. MOTHER'S MAIDEN NAME <u>FLORIENCE HORINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-18-246</u>			
17. INFORMANT <u>HERBERT W. SMITH</u>				Address <u>HAGERSTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u> 491X DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compensatory heart failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1960</u> to <u>June 12, 1960</u> ; that (I) (we) last saw the deceased alive on <u>June 12, 1960</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondary</u>				22b. DATE SIGNED <u>June 12, 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARY</u>				22d. ADDRESS <u>BOONSBORO MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 15, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>				25a. REC'D BY REGISTRAR <u>Boonsboro MD.</u>			
25b. REGISTRAR'S SIGNATURE <u>John H. Best</u>				DATE <u>JUN 17 60</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07422

7418 Item 8 Film 264-6-8-60 et

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washingtonn County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle JULIA Last SOCKS				4. DATE OF DEATH Month June Day 1 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26 1914	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 45 Days 1 Hours 1 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME WILLIAM DIDDLEBOCK				14. MOTHER'S MAIDEN NAME MARY SOCKS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Robert H Socks Address Cumberland Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Postoperative atelectasis and pneumonia							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-15-60 to 6-1-60 19, that (I) (we) last saw the deceased alive on 5-31-60 19, and that death occurred at 2:15 A M, from the causes and on the date stated above.							
22a. SIGNATURE Paul Harrison				22b. DATE SIGNED 6-3-60			
22c. PHYSICIAN'S NAME (Type) Paul Harrison M D				22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24a. NAME OF DIRECTOR OF BURIALS Charles M Rouker				24b. ADDRESS Hagerstown Maryland			
25a. REC'D BY REGISTRAR DATE JUN 6 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2418



Registration
Hospital
County Hospital
Name
Sex
Age
Date of Birth
Date of Death
Place of Birth
Cause of Death
Manner of Death
Signature
Physician
Witness
No.



Signature of Physician
Signature of Witness
Date
Place
County
State

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VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7419 CERTIFICATE OF DEATH 302 07423

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 10 Mi. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 88 West Lee St		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 2100 Hillandale Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT WILSON SOUTH		4. DATE OF DEATH Month Day Year June 7 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 16 1918
9. AGE (In years lost birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Tavern Operator Funkstown Wash Co	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roy O. South		14. MOTHER'S MAIDEN NAME Naomi Knott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.# 3 220-05-6109	
17. INFORMANT Mrs Dorothy South		Address 2100 Hillandale Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None.		INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1957 to June 7, 1960 that (I) (we) last saw the deceased alive on June 6, 1960 and that death occurred at 8:15 P from the causes and on the date stated above.			
22a. SIGNATURE R. A. Bell		22b. DATE SIGNED June 9, 1960.	
22c. PHYSICIAN'S NAME (Type) R. A. Bell, M.D.		22d. ADDRESS Hagerstown, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Havnen Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR JUN 13 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Route#4 d. STREET ADDRESS Cearfoss e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jacob Roman Stockslager		4. DATE OF DEATH Month June Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 21 1882
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash 3/4 Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob R. Stockslager		14. MOTHER'S MAIDEN NAME Mary Eliz Winter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Raymond W. Stockslager		Address Hagerstown Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Alumina DUE TO Nephrosclerosis + Prostatic obst. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Chronic		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 25 July 1951 to 23 June 1960 , that (I) (we) last saw the deceased alive on 23 June 1960 , and that death occurred at 8:14 P M, from the causes and on the date stated above.			
22a. SIGNATURE Richard T. Binford		22b. DATE SIGNED 24 JUNE 60	
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		22d. ADDRESS 1135 POTOMAC AVENUE, HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash 3/4 Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR JUN 28 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hance	

STATE OF NEW YORK
JULY 1951

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Washington County, New York
H. J. Davis
H. J. Davis

H. J. Davis
H. J. Davis

Washington County, New York

Jacob Roman
Stocking
June 18 1950

Male
June 18 1950

United States
H. J. Davis

Jacob B. Stocking
H. J. Davis

H. J. Davis
H. J. Davis

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Hancock Md</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Little Pool Near Hancock Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 1 Hancock Maryland</u> d. STREET ADDRESS <u>Rural 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Seibert</u> Last <u>Stotler</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>19 60</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4.23.1916</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Painting</u>				11. BIRTHPLACE (State or foreign country) <u>Morgan County W.VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Stotler</u>						14. MOTHER'S MAIDEN NAME <u>Irene Waugh</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>World War 2.232-26-6304</u>				17. INFORMANT <u>Mary F Stotler Rural 1 Hancock Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>850x</u> DUE TO <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Either slipped or fell from foot in Little Pool (canal)</u>									
20c. TIME OF INJURY Month, Day, Year <u>6-5-1960</u> Hour <u>3:30</u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Canal</u>		20f. (City or town) <u>Hancock</u>		(County) <u>Washington</u>		(State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>D. E. W. Stotler</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>6/5/60</u>	
EXAMINER'S NAME (Type) <u>D. E. W. Stotler</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6.8.60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Morgan County W.VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>						ADDRESS <u>Hancock Md</u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1998

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Boonsboro</u>		c. LENGTH OF STAY IN 1b <u>years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>C.</u> Last <u>Stottlemeyer</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/1881</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Hamilton Stottlemeyer</u>	
14. MOTHER'S MAIDEN NAME <u>Susanna Hoover</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Mrs. Mary Stottlemeyer, Boonsboro, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sanguine of both lower legs</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 15, 1950</u> to <u>June 14, 1960</u> that I last saw the deceased alive on <u>June 14, 1960</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Secondari</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>		<u>BOONSBORO MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/16/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company,</u>		ADDRESS <u>Middletown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-45

CERTIFICATE OF DEATH

1933



1



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Blank certificate form with horizontal lines for text entry.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7422 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07427									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY SUFFOLK				
b. CITY OR TOWN (If outside corporate limits, write RURAL) HAGERSTOWN			c. LENGTH OF STAY IN lb 1 WEEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST ISLIP LONG ISLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 163 MALTS AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TINA Middle LEE Last TRUMPOWER					4. DATE OF DEATH Month JUNE Day 8 Year 19 60				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/4/1957		9. AGE (In years last birthday) 2 yrs.	
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LLOYD KENNETH TRUMPOWER					14. MOTHER'S MAIDEN NAME SHIRLEY BRINING				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT MRS. EDITH TRUMPOWER		Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extra dual hematoma due to fracture of 8 ribs + severe middle meningeal artery 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 8 days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Playing in yard with grandfather - fell from his arm and struck head on ground					
20c. TIME OF INJURY Month, Day, Year Hour 4 -- 30 min p. m. 6 6 19 60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) About Home		20f. (City or town) (County) (State) Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Edward W. Ditto III M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/9/60		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD		
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md					24a. REC'D BY REGISTRAR JUN 10 '60		24b. REGISTRAR'S SIGNATURE C. L. S. Harris		

DATE SIGNED

6/8/60

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7423
CERTIFICATE OF DEATH
07428

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>Dianne</u> Last <u>Weller</u>		4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6.6.1960</u>
9. AGE (In years last birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard J Weller Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta M Hose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Howard J Weller Jr</u>		Address <u>Rural 2 Hancock Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO (b) <u>Intestinal illness</u> DUE TO (c) <u>2d</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immaturity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6 June 1960</u> to <u>14 June 1960</u> , that (I) (we) last saw the deceased alive on <u>14 June 1960</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold H. Gist</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD H-GIST M.D.</u>		22d. ADDRESS <u>111 N. Potomac St. HAGERSTOWN MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6.15.60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Orchard Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Rural Hancock Washington Md</u>	

24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J Stone</u>		25a. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
ADDRESS <u>Hancock Md</u>		DATE <u>JUN 20 1960</u>	

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MAILED AND SENT DEPARTMENT OF HEALTH
JAN 24 1964

433

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07429

7424

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 19 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Kenneth Middle Wheeler, Sr. Last		4. DATE OF DEATH June 15, 1960 Month June Day 15 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ex. Vice Pres.		10b. KIND OF BUSINESS OR INDUSTRY refrigeration Mfg. Berwick, Penna.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry C. Wheeler		14. MOTHER'S MAIDEN NAME Vernie Kingsbury	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-09-8024	
17. INFORMANT Wilba Wheeler, Hagerstown, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) (Treated Hypertension) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-14 , 19 60 , to 6-15-60 , 19 60 , that I last saw the deceased alive on 6-15 , 19 60 , and that death occurred at 6:30 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert P. Conrad M.D.		ADDRESS (Street, city or town, state) 137 W. Washington DATE SIGNED 6-15-60	
PHYSICIAN'S NAME (Type) Robert P. Conrad, MD		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6-18-60	22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery	22d. LOCATION (City, town, or county) (State) Berwick, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md. ADDRESS		24a. REC'D BY REGISTRAR JUN 20 '60	24b. REGISTRAR'S SIGNATURE Arthur L. House



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1990-1991

Volume 11, Number 1

2025 RELEASE UNDER E.O. 14176

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining pages to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

See TB
M
091

37425
Item 14 Film 206 7-6-60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07430

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminister</u>			
c. LENGTH OF STAY IN lb <u>3 months</u>				d. STREET ADDRESS <u>Alms House</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>WHITE</u>				4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2, 1892</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Albert White</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Becraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Hospital record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of blood</u> 1419 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Carcinoma of the tongue</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>1 year</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 16, 1960</u> to <u>June 20, 1960</u> , that (I) (we) lost saw the deceased alive on <u>June 20, 1960</u> , and that death occurred on <u>June 20, 1960</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u>				22b. DATE SIGNED <u>June 21, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>				22d. ADDRESS <u>1500 Penna Ave Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>6-22-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Bld. U. of Md.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR <u>JUN 27 '60</u>			
ADDRESS				25b. REGISTRAR'S SIGNATURE <u>Young E. Chun</u>			

00130

CERTIFICATE OF DEATH

1922

(M)

Name of Deceased *Henry White*
 Date of Death *Sept. 18, 1922*
 Place of Death *Western Mt. State Hospital*
 Age *35*
 Sex *Male*
 Cause of Death *Heart Disease*
 Signature of Physician *[Signature]*
 Date of Certificate *Sept. 20, 1922*

(1)

Registrar of Births and Deaths
 County of *Jefferson*
 State of *West Virginia*

This is to certify that the foregoing is a true and correct copy of the original certificate of death filed in the office of the Registrar of Births and Deaths of the County of *Jefferson*, State of *West Virginia*, on the *20th* day of *September*, 1922.
 Registrar of Births and Deaths
[Signature]
 Date *Sept. 20, 1922*

CERTIFICATE OF DEATH

Reg. Dist. **07431**

7426

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Idia Middle Etta Last Wolfe		4. DATE OF DEATH Month June Day 15 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Garfield, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Roman Wolfe		14. MOTHER'S MAIDEN NAME Laurah Kuhn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-18-1185	
17. INFORMANT Charles F. Wolfe, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Agranulocytosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Probable Aspirin Toxicity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH 3 Wks.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/3 , 19 54 , to 6/15 , 19 60 , that I last saw the deceased alive on 6/15 , 19 60 , and that death occurred at 9:35 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 6/16/60	
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		Smithsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-19-60	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Washington

MA.

Smithsburg

15 days

Hagerstown

Washington County Hospital

RD 1

80

15

June

Wolfe

Male

Male

Female white

Aug. 2, 1988

70

Housewife

Getfield, MA.

Lanham Room

Room Wolfe

Charles A. Wolfe, Smithsburg, MD.

820-18-1185

no

23 - 2000/1000000

Protein Analysis Toxicology

1000-18-1185

Charles E. Wolfe

Smithsburg Cemetery, Smithsburg, MD.

6-18-80

Booth Y. Winfield & Son, Smithsburg, MD.